1915(i) HCBS State Plan Services

Administration and Operation

1. **Program Title** (*optional*): 1915(i) HCBS State Plan Program

2. **State-wideness.** *(Select one)*:

⊙	The State implements this supplemental benefit package statewide, per §1902(a)(1) of the Act.
○	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. *(Check each that applies):*
	☐ Geographic Limitation. HCBS state plan services will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. *(Specify the areas to which this option applies)*:
	☐ Limited Implementation of Participant-Direction. HCBS state plan services will be implemented without regard to state-wideness requirements to allow for the limited implementation of participant-direction. Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *(Specify the areas of the State affected by this option)*:

3 **State Medicaid Agency (SMA) Line of Authority for Operating the HCBS State Plan Supplemental Benefit Package.** *(Select one)*:

⊙	The HCBS state plan supplemental benefit package is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	⊙ The Medical Assistance Unit *(name of unit)*:	Iowa Medicaid Enterprise
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)*	
○	The HCBS state plan supplemental benefit package is operated by *(name of agency)*	
	a separate agency of the State that is not a division/unit of the Medicaid agency. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State Plan HCBS Operational and Administrative Functions.

☑ The State assures that in accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration or supervision of the state plan. When a function is performed by other than the Medicaid agency, the entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities.

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Disseminate information concerning the state plan HCBS to potential enrollees	☑	☐	☑	☐
2 Assist individuals in state plan HCBS enrollment	☑	☐	☐	☐
3 Manage state plan HCBS enrollment against approved limits, if any	☑	☐	☐	☐
4 Review participant service plans to ensure that state plan HCBS requirements are met	☑	☐	☑	☐
5 Recommend the prior authorization of state plan HCBS	☑	☐	☑	☐
6 Conduct utilization management functions	☑	☐	☑	☐
7 Recruit providers	☑	☐	☑	☐
8 Execute the Medicaid provider agreement	☑	☐	☑	☐
9 Conduct training and technical assistance concerning state plan HCBS requirements	☑	☐	☑	☐
10 Conduct quality monitoring of individual health and welfare and State plan HCBS program performance.	☑	☐	☑	☐

(Specify, as numbered above, the agencies/entities(other than the SMA) that perform each function):

1. Information for potential enrollees may be disseminated by IME Policy staff, or by the Iowa Medicaid Enterprise's contractor for member services, Maximus Inc.

4. Service plan review is primarily done by the Iowa Medicaid Enterprise's contractor for medical services, the Iowa Foundation for Medical Care. This function may also be completed by the Iowa Medicaid Enterprise's Policy staff.

5. Recommendation for prior authorization is primarily done by the Iowa Medicaid Enterprise's contractor for medical services, the Iowa Foundation for Medical Care through the service plan review process. This function may also be completed by Iowa Medicaid Enterprise policy staff. Prior authorizations are done through the ISIS system, which enforces parameters such as unit and rate caps set by the Iowa Medicaid Enterprise.

6. Utilization management functions are set by Iowa Medicaid Enterprise policy staff and primarily carried out by the Iowa Medicaid Enterprise's contractor for medical services, the Iowa Foundation for Medical Care (IFMC). Needs-based eligibility criteria are determined by Iowa Medicaid Enterprise policy staff. IFMC reviews the needs-based evaluation to ensure the member meets the needs-based eligibility criteria. Parameters for prior authorization are determined by Iowa Medicaid Enterprise policy staff and are enforced through the ISIS system. IFMC reviews and authorizes service plan data in the ISIS system.

7. Recruitment of providers may be done by Iowa Medicaid Enterprise policy staff, or by the Iowa Medicaid Enterprise's contractor for provider services, Policy Studies Inc.

8. Execution of the provider agreement is primarily done by the Iowa Medicaid Enterprise's contractor for provider services, Policy Studies Inc. on behalf of the Iowa Medicaid Enterprise. The provider agreement has been written by Iowa Medicaid Enterprise staff in conjunction with the Iowa Attorney General's office.

9. Training and technical assistance is overseen by Iowa Medicaid Enterprise policy staff and primarily implemented by the Iowa Medicaid Enterprise's HCBS quality assurance and improvement contractor, Iowa State University. Iowa Medicaid Enterprise policy staff also conducts training as needed.

10. Quality monitoring is overseen by Iowa Medicaid Enterprise policy staff and primarily implemented by the Iowa Medicaid Enterprise's HCBS quality assurance and improvement contractor, Iowa State University.

5. ☑ **Conflict of Interest Standards.** The State assures it has written conflict of interest standards that, at a minimum, address the conduct of individual assessments and eligibility determinations.

6. ☑ **Appeals**. The State allows for appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in HCBS state plan services.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.** *(Specify):*

Annual Period	From	To	Projected Number of Participants
Year 1	1/1/2007	12/31/2007	3700
Year 2	1/1/2008	12/31/2008	3885
Year 3	1/1/2009	12/31/2009	4079
Year 4	1/1/2010	12/31/2010	4283
Year 5	1/1/2011	12/31/2011	4497

2. **Optional Annual Limit on Number Served.** *(Select one):*

◉	The State does not limit the number of individuals served during the Year.
○	The State chooses to limit the number of individuals served during the Year. *(Specify):*

Annual Period	From	To	Annual Maximum Number of Participants

☐	The State chooses to further schedule limits within the above annual period(s). *(Specify):*

3. **Waiting List.** *(Select one):*

◉	The State will not maintain a waiting list.
○	The State will maintain a single list for entrance to the HCBS state plan supplemental benefit package. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; ensure that otherwise eligible individuals have comparable access to all services offered in the package.

Financial Eligibility

1. ☑ **Income Limits.** The State assures that individuals receiving state plan HCBS are in an eligibility group covered under the State's Medicaid state plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL).

2. **Medically Needy.** *(Select one):*

○	The State does not provide HCBS state plan services to the medically needy.
◉	The State provides HCBS state plan services to the medically needy *(select one):*
○	The State elects to waive the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
◉	The State does not elect to waive the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Independent evaluations/reevaluations to determine whether applicants are eligible for HCBS are performed (*select one*):

○	Directly by the Medicaid agency
⊙	By Other (*specify*):
	The Iowa Medicaid Enterprise Medical Services unit is responsible for annual approval. The Medical Services Unit is staffed through the Iowa Medicaid Enterprise's contract with the Iowa Foundation for Medical Care as noted in the above section titled "Distribution of State Plan HCBS Operational and Administrative Functions".

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** There are qualifications (that are reasonably related to performing evaluations) for persons responsible for evaluation/reevaluation for eligibility. *(Specify qualifications):*

The IME Medical Services unit requires that the individuals performing evaluations must be:
- a licensed practitioner of the healing arts –or-
- have a four-year health-related degree –or-
- be a registered nurse licensed in the State of Iowa with a minimum of 2 years experience providing relevant services

3. ☑ **Independence of Evaluators and Assessors.** The State assures that evaluators of eligibility for HCBS state plan services and assessors of the need for services are independent. They are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - service providers, or individuals or corporations with financial relationships with any service provider.

4. **Needs-based HCBS Eligibility Criteria.** Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for HCBS state plan services. The criteria take into account the individual's support needs and capabilities and may take into account the individual's ability to perform two or more ADLs, the need for assistance, and other risk factors: *(Specify the needs-based criteria):*

The individual meets at least one of the following risk factors:

- Has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). Individuals currently undergoing inpatient hospitalization demonstrate this risk factor, but cannot receive 1915(i) HCBS State Plan Services while in an institution, including hospitals.
- Has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

In addition, the person has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

- Is unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
- Requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- Shows severe inability to establish or maintain a personal social support system.
- Requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management.
- Exhibits inappropriate social behavior that results in demand for intervention.

5. ☑ **Needs-based Institutional and Waiver Criteria.** There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of HCBS state plan services. Individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Include copies of the State's official documentation of the need-based criteria for each of the following):*

- *Applicable Hospital*
- *NF*
- *ICF/MR*

Differences Between Level of Care Criteria

State Plan HCBS Needs-based eligibility criteria	NF (& NF Level of Care Waivers)	ICF/MR (& ICF/MR Level of Care Waivers)	Applicable Hospital Level of Care (Psychiatric Hospital)
The individual meets at least one of the following risk factors: o Has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or inpatient hospitalization). Individuals currently undergoing inpatient	Based on the Minimum Data Set (MDS) section G, the individual requires supervision, or limited assistance provided on a daily basis by the physical assistance of at least one person, for dressing and personal hygiene activities of daily living –OR— Based on the MDS, the individual requires the establishment of a safe,	1. A diagnosis of mental retardation before 18 years of age as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or a related condition as defined by the Code of Federal Regulations 41 CFR 435.1009. --AND-- 2. Three or more deficits resulting in substantial functional	**Mental Status:** A. Need for 24-hour professional observation, evaluation and/or diagnosis of a patient exhibiting behaviors consistent with acute psychiatric disorder, which may include significant mental status changes. B. Documented failure of current outpatient treatment including two or more of the following necessitating 24 hour professional observation supported by medical record documentation: o exacerbation of

hospitalization demonstrate this risk factor, but cannot receive 1915(i) HCBS State Plan Services while in an institution, including hospitals. o Has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization. --AND-- Has a need for assistance typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years: o Is unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history. o Requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help. o Shows severe inability to establish or maintain a personal social support system. o Requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management. o Exhibits inappropriate social behavior that results in demand for	secure environment due to modified independence (some difficulty in new situations only) or moderate impairment (decisions poor, cues and supervision required; never or rarely made a decision; danger to self or others) of cognitive skills for daily decision-making: o Cognitive, Mood and behavior patterns o Physical functioning-Mobility o Skin condition o Pulmonary Status o Continence o Dressing and Personal Hygiene (ADL's) o Nutrition o Medications o Communication o Psycho-social	limitation in major life activity areas as defined in 42 CFR 435.1009(d): o Self-care o Understanding and use of language o Learning o Mobility o Self Direction o Capacity for independent living	symptoms o noncompliance with medication regimen o lack of therapeutic response to medication o acute neuroleptic reaction o psychotropic or neuroleptic medication toxicity o lack of patient participation in the outpatient treatment program Information regarding prior hospitalizations and length of stay will be obtained as well as evaluation of the patient's medical stability to participate in a comprehensive treatment plan.

intervention.			

6. ☑ **Reevaluation Schedule**. The State assures that needs-based reevaluations are conducted at least annually.

7. ☑ **Adjustment Authority**. The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

Person-Centered Planning & Service Delivery

1. ☑ The State assures that there is an independent assessment of individuals determined to be eligible for HCBS. The assessment is based on:
   - An objective face-to-face evaluation by a trained independent agent;
   - Consultation with the individual and others as appropriate;
   - An examination of the individual's relevant history, medical records, care and support needs, and preferences;
   - Objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more ADLs (as defined in § 7702B(c)(2)(B) of the Internal Revenue Code of 1986); and
   - Where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct.
2. ☑ The State assures that, based on the independent assessment, the individualized plan of care:
   - Is developed by a person-centered process in consultation with the individual, the individual's: treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and where appropriate the individual's family, caregiver, or representative;
   - Identifies the necessary HCBS to be furnished to the individual, (or, funded for the individual, if the individual elects to participant-direct the purchase of such services);
   - Takes into account the extent of, and need for, any family or other supports for the individual;
   - Prevents the provision of unnecessary or inappropriate care;
   - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
   - Is reviewed at least annually and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

   Educational/professional qualifications of individuals conducting assessments are as follows:
   1. Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of relevant services.

   -Or-

   2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services.
4. **Responsibility for Service Plan Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

Individualized, person-centered plans of care will be developed by individuals with the following educational/professional qualifications:

1. Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of relevant services.

-Or-

2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services.

5. **Supporting the Participant in Service Plan Development**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

(a) The service plan is developed by the participant and his or her interdisciplinary team based on information from the needs-based assessment, and taking into account the participant's social history, and treatment and service history. The case manager acts as an advocate for the participant in this process and is a source of information for the participant and the team. The participant and the team identify the participant's strengths, needs, preferences, desired outcomes, and his or her desires in order to determine the scope of services needed. The case manager informs the participant of all available Medicaid and non-Medicaid services. The participant is encouraged to choose goals based on his or her own desires while recognizing the need for supports to attain those goals.

(b) The interdisciplinary team includes the participant; his or her legal representative if applicable; the case manager; and any other persons the participant chooses, which may include service providers. Individuals that are not Medicaid providers are not reimbursed for their participation.

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the service plan):*

The case manager informs the participant and his or her interdisciplinary team of all available qualified providers. This is part of the interdisciplinary team process when the service plan is developed, and again whenever it is renewed or revised. Participants are encouraged to meet with the available providers before choosing a provider.

7. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the service plan is made subject to the approval of the Medicaid agency):*

The Iowa Department of Human Services has developed a computer system named the Individualized Services Information System (ISIS) to support certain Medicaid programs. This system assists with tracking information and monitoring the service plan and enforces parameters such as unit and rate caps set by the department. Case managers complete the assessment of the need for services and submit it to the IME Medical Services unit for evaluation of program eligibility. The case manager is also responsible for entering service plan information such as the services to be received, the effective dates, the amount of each service, and the selected provider into ISIS, where it is reviewed for authorization by IME Medical Services staff.

8. **Maintenance of Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency	☐	Operating agency	☑	Case manager
☐	Other *(specify):*				

Services

1. HCBS State Plan Services. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B):*			
Service Title:	**HCBS Case Management**		
Service Definition (Scope):			
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Individuals who receive Targeted Case Management under the Medicaid State plan cannot also receive case management under Section 1915(i). Participants are free to choose their provider from any enrolled provider of this service.			
Additional needs-based criteria for receiving the service, if applicable *(specify):*			
Participants have a need for support and assistance in accessing services.			
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*			
☐	Categorically needy *(specify limits):*		
☐	Medically needy *(specify limits):*		
Specify whether the service may be provided by a *(check each that applies):*		☐	Relative
		☐	Legal Guardian
		☐	Legally Responsible Person

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Case Management Provider		Providers must be certified under Iowa Administrative Code 441-24, which includes meeting the following qualifications: 1. Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of relevant services. -Or- 2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services.	

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as*

needed):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Case Management Provider	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification (either 270 days, 1 year, or 3 years)

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title from the options for HCBS State plan services in Attachment 4.19-B)*:

Service Title: **Habilitation**

Service Definition (Scope):

Services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Components of this service include the following:

1. Home-based Habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community.

These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation also includes personal care and protective oversight and supervision. Home-based habilitation is not covered for participants residing in a residential care facility of more than 16 persons. Services provided in a licensed residential care facility of 16 or fewer persons will be considered to take place in the participant's home when the participant's service plan documents that the participant resides there by their own choice, and is provided with opportunities for independence and community integration. Participants are free to choose their provider from any enrolled provider of this service. The service plan will include a discharge plan and documentation of any rights restrictions. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement.

2. Day Habilitation means assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week or as specified in the participant's service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings. Participants are free to choose their provider from any enrolled provider of this service.

3. Prevocational Habilitation means services that prepare a participant for paid or unpaid employment. Services include teaching such concepts as compliance, attendance, task completion,

problem solving and safety. Services are not job-task oriented, but instead, aimed at a generalized result. Services are reflected in the participant's service plan and are directed to habilitative rather than explicit employment objectives. Participants are free to choose their provider from any enrolled provider of this service. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

4. Supported Employment Habilitation means services that consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings, particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations which do not include those for which providers are already responsible to make in order to meet requirements of the Americans with Disabilities Act, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting. Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that is not directly related to an individual's supported employment program.

Participants are free to choose their provider from any enrolled provider of this service.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

Participants have a need for supports to assist in the acquisition, retention, or improvement in skills related to living in the community. Additionally, for the prevocational habilitation and supported employment habilitation components, individuals have a need for ongoing supports to prepare for, obtain, or maintain employment.

Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies)*:

☑ Categorically needy *(specify limits)*:

For the supported employment component, a unit of service for "activities to obtain a job" is one job placement. A unit of service for "supports to maintain employment" is an hour with a maximum of 40 units per week.

For all other components, a unit of service is hourly, half-day or a day. There is an upper limit for these services per hour, per half-day, or per day.

All limits are subject to change each year. All components of habilitation being utilized must be authorized in the participant's service plan. The case manager will monitor the service plan.

☑ Medically needy *(specify limits)*:

	For the supported employment component, a unit of service for "activities to obtain a job" is one job placement. A unit of service for "supports to maintain employment" is an hour with a maximum of 40 units per week. For all other components, a unit of service is hourly, half-day or a day. There is an upper limit for these services per hour, per half-day, or per day. All limits are subject to change each year. All components of habilitation being utilized must be authorized in the participant's service plan. The case manager will monitor the service plan.

Specify whether the service may be provided by a *(check each that applies):*	☐	Relative
	☐	Legal Guardian
	☐	Legally Responsible Person

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Home-based habilitation providers		Meet any of the following: o Accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF) o Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) o Accredited by the Council on Accreditation (COA) o Accredited by the Council on Quality and Leadership (CQL) o Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Supported Community Living for the HCBS MR Waiver under 441-IAC 77.37(1) through 77.37(14) or the HCBS BI Waiver under 441-IAC 77.39(1) through 77.39(10) and 77.39(13). o Certified by the department as a provider of Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.4(12).	
Day habilitation providers		Meet any of the following: o Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) o Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) o Accredited by the Council on Quality and Leadership (CQL) o Accredited by the International Center for Clubhouse Development (ICCD) o Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Day Habilitation for the HCBS MR Waiver under 441	

		IAC 77.37(13) and 77.37(27). o Certified by the department as a provider of Day Treatment under 441-IAC 24.2 through 24.4(8) and 24.4(10) or Supported Community Living under 441-IAC 24.2 through 24.4(8) and 24.4(12).	
Prevocational habilitation providers		Meet any of the following: o Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) o Accredited by the Council on Quality and Leadership (CQL) o Accredited by the International Center for Clubhouse Development (ICCD) o Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Prevocational services for the HCBS MR Waiver under 441 IAC 77.37(13) and 77.37(26) or the HCBS BI Waiver under 441-IAC 77.39(22).	
Supported employment habilitation providers		Meet any of the following: o Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) o Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) o Accredited by the Council on Accreditation (COA) o Accredited by the Council on Quality and Leadership (CQL) o Accredited by the International Center for Clubhouse Development (ICCD) o Certified by the bureau of long term care of the Iowa Medicaid Enterprise as a provider of Supported Employment for the HCBS MR Waiver under 441 IAC 77.37(1) through 77.37(13) and 77.37(16) or the HCBS BI Waiver under 441-IAC 77.39(1) through 77.39 (10) and 77.39(15).	

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Home-based habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification: o either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers or certified

		under IAC 441-24 o either 1 year or 3 years when accredited by CARF; either 3 years or 4 years when accredited by COA; o 3 years when accredited by JCAHO o 4 years when accredited by CQL
Day habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification: o either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR Waiver or certified under IAC 441-24 o either 1 year or 3 years when accredited by CARF or ICCD o 3 years when accredited by JCAHO o 4 years when accredited by CQL
Prevocational habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification: o either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers o either 1 year or 3 years when accredited by CARF or ICCD o 4 years when accredited by CQL
Supported employment habilitation providers	Iowa Department of Human Services, Iowa Medicaid Enterprise	Verified at initial certification and thereafter based on the length of the certification: o either 270 days, 1 year, or 3 years when certified by the IME as a provider for HCBS MR or BI Waivers o either 1 year or 3 years when accredited by CARF or ICCD o either 3 years or 4 years when accredited by COA o 3 years when accredited by JCAHO o 4 years when accredited by CQL

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

2. Policies Concerning Payment for State Plan HCBS Furnished by Legally Responsible Individuals, Other Relatives and Legal Guardians. *(Select one):*

◉	The State does not make payment to legally responsible individuals, other relatives or legal guardians for furnishing state plan HCBS.
○	The State makes payment to *(check each that applies):*
☐	**Legally Responsible Individuals.** The State makes payment to legally responsible individuals under specific circumstances and only when the relative is qualified to furnish services. *(Specify (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) in cases where legally responsible individuals are permitted to furnish personal care or similar services, the State must assure and describe its policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual); (c) how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the State's strategies for ongoing monitoring of the provision of services by legally responsible individuals; and, (e) the controls that are employed to ensure that payments are made only for services rendered):*
☐	**Relatives.** The State makes payment to relatives under specific circumstances and only when the relative is qualified to furnish services. *(Specify: (a) the types of relatives who may be paid to furnish such services, and the services they may provide, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by relatives, and; (d) the controls that are employed to ensure that payments are made only for services rendered):*
☐	**Legal Guardians.** The State makes payment to legal guardians under specific circumstances and only when the guardian is qualified to furnish services. *(Specify: (a) the types of services for which payment may be made, (b) the specific circumstances under which payment is made; (c) the State's strategies for ongoing monitoring of the provision of services by legal guardians, and; (d) the controls that are employed to ensure that payments are made only for services rendered):*
☐	**Other policy.** *(Specify)*:

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction.** *(Select one):*

⊙	The State does not offer opportunity for participant-direction of state plan HCBS.
○	Every participant in HCBS state plan services (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in HCBS state plan services (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the HCBS State Plan option, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. **Participant-Directed Services.** *(Indicate the HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

4. **Financial Management.** *(Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as an administrative function.

5. ☐ **Participant–Directed Service Plan.** The State assures that, based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:
   - Is directed by the individual or authorized representative and builds upon the individual's preferences and capacity to engage in activities that promote community life;
   - Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
   - For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
   - For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
   - Includes appropriate risk management techniques.

6. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

7. **Opportunities for Participant-Direction**

a. **Participant–Employer Authority** (individual can hire and supervise staff). *(Select one):*

○	The State does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. **Participant–Budget Authority** (individual directs a budget). *(Select one):*

○	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

Quality Management Strategy

(Describe the State's quality management strategy in the table below):

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
Service plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	1.Review of plans after they are developed. 2. Quality Assurance review process	1. Service worker supervisor or case management supervisor. 2. DHS quality assurance staff	1. Service plan checklist in file 2. Consumer interview.	Yes.	1. All plans at least every 12 months 2. Continuous; by random sample of 200 providers per year.
Providers meet required qualifications	1. Annual compliance review 2. File and organization outcomes review	1. IME provider services unit 2. DHS quality assurance staff	1. Documentation of certification 2. required certification or licensure	No.	1. Sample of 200 HCBS providers per year 2. All providers once every three years
The SMA retains authority and responsibility for program operations and oversight.	1. Program oversight by DHS's Iowa Medicaid Enterprise. 2. DHS bureau of long-term care contracts with Iowa State University for quality assurance.	1. Program policy specialist 2. DHS monitors contract with Iowa State University.	1. State plan, administrative rules, provider manuals. 2. Quality assurance plan; activity tracking.	1. Yes. 2. Yes.	1. Continuous. 2. Contract with Iowa State University is monitored quarterly.
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.	1. ISIS system assures claims are paid within authorized limits for each individual. 2. Billing audits	1. IME data warehouse and CORE units. 2. DHS Bureau of purchased services.	1. Authorization data. 2. MMIS claims history, ISIS authorization	1. Yes. 2. Yes.	1. Continuous. 2. Continuous.

			data, and provider files.		
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. Service plans address health and welfare and contain individualized emergency plans. 2. Incident reporting to DHS. 3. Abuse and neglect reports.	1. Case managers. 2. Providers (with compliance checks by DHS QA staff). 3. DHS Child and Adult Protective Bureau	1. Service plans. 2. Incident reports 3. Abuse and neglect reports.	1. No. 2. Yes. 3. Yes.	1. All plans at least every 12 months 2. All incident reports; continuously. 3. All abuse or neglect reports; continuously.
Describe the process(es) for remediation and systems improvement.	**Overall System** The QA/QI system, at a minimum, addresses: • Health and safety issues of consumers receiving HCBS services • Abuse/neglect/exploitation of consumers • Consumer access to services • Plan of Care discrepancies • Availability of services • Complaints of service delivery • Training of providers, case managers, and other stakeholders • Emergency procedures • Provider qualifications • Consumer choice The QA/QI system shall continuously collect data for use in improving quality of services. Data shall come from a variety of sources including HCBS provider databases, site reviews, follow-up compliance reviews, complaint investigations, evaluation reports, consumer satisfaction surveys, consumer interviews, and consumer records. Data from all QA/QI activities is compiled by the HCBS QA Specialists and presented to the HCBS QA/QI committee on a quarterly basis. The QA/QI committee analyzes the data to determine patterns, trends, problems, and issues in service delivery of HCBS services. Based on this analysis, recommendations for changes in policy are made to the IME Policy staff and Bureau Chief. The committee also uses this information to direct HCBS Specialists to provide training, technical assistance, or other activity. The committee monitors training and technical assistance activities to assure consistent implementation statewide. The QA/QI committee is made up of certain HCBS Quality Assurance staff and supervisors (who function under the Iowa State University contract),				

and DHS Policy staff. Minutes are taken at each of the meetings, which show evidence that analysis of data is completed and recommendations for remediation and system improvement are made

Service Plans
All consumers have a consumer centered, outcome based service plan of care developed by the interdisciplinary team to address all assessed needs and health and safety risk factors of consumer as well as personal goals. Services plans will address both met and unmet needs of the consumer. Service plans are updated and revised annually or as a consumer's needs change. The consumer is informed of their right to change their plan at anytime and they acknowledge this by signing a service plan checklist. The Case Manager will monitor the service plan on a monthly basis to assure that services are delivered in the type, scope, amount, duration and frequency are delivered in accordance with the plan. All service plans are reviewed by the local supervisor of case managers for approval after they are developed. On an annual basis, IME will randomly select 200 HCBS providers for Quality Assurance review. The 200 providers shall be selected based on length of time the provider has been an HCBS provider, starting with the providers with the longest HCBS history selected first. The selection of providers will continue with another 200 provider selected until all providers have been reviewed. The QA review process includes desk reviews of provider records and on-site reviews. On-site reviews include a review of records and documentation of services, staff interviews, and consumer interviews. During the QA review process, service plans are monitored to assure that assessed needs are being identified in the service plan and are updated and revised as needed. If systematic inadequacies in service plan development are found through the QA process, training packets are sent out , regional trainings are held, and a report is made to the QA/QI committee which may recommend further action as described above under "overall system".

During the service plan development, consumers are presented with an option of available providers in their area and are given a choice on what provider they want to use. In addition a service plan checklist is used by case manager that identifies that the consumer was presented with choice. The consumer and the case manger sign off on the checklist and it becomes part of the consumer's file. The case manager incorporates and approves the chosen provider into the service plan. As a follow up, during the QA interview process, consumers are asked if they had a choice of providers and also review files for documentation.

Qualified Providers
On an Annual basis, IME provider services will randomly select 200 HCBS providers, both licensed and non-licensed, to review eligibility criteria. Information will be requested from the provider that documents current compliance with eligibility criteria for each program and each service that the provider is certified/enrolled to provide as listed on the ISIS system. The 200 providers shall be selected based on length of time the provider has been an HCBS provider, starting with the providers with the longest HCBS history selected first. The selection of providers will continue with another 200 provider selected until all providers have been reviewed. The cycle

	will start over when all providers have been reviewed. A series of letters shall be sent to each provider requesting that the provider submit information stating how the provider meets eligibility criteria for each HCBS service they are certified/enrolled to provide. If providers do not respond to these requests within the timeframes identified in the letter, termination in the Medicaid program will occur. The Department of Human Services, Bureau of Purchased Services does random audits of providers to ensure that they meet state and federal requirements. Through the QA process, DHS currently does a random sampling of providers to review files and organizational outcomes. DHS is in the process of implementing a quality assurance process that will review all provider agencies in the state once in a three-year period. This file review will include a discover process to ensure that training and education is provided based on the certification or licensure needed for each provider. After each review, the HCBS specialist identifies if any deficiencies exist and work individually with the provider to develop a corrective action plan. In addition, if systemic deficiencies are found with providers, HCBS specialists will provide training in the regional quarterly meetings. **SMA Authority** DHS sets policy and provides oversight over the program. The Bureau of Long Term Care contracts with Iowa State University to provide quality assurance activities. Iowa State University is the only entity that that the SMA currently delegates quality assurance activities to. There is a contract that specifies the exact functions that Iowa State University is to carry out for the SMA. The contract was awarded through a competitive bidding process. Performance measures are included in the contract and are monitored quarterly by SMA policy staff. DHS is responsible for the following Contractor internal quality assurance functions: 1. Consult with the contractor on quality improvement measures and determination of areas to be reviewed. 2. Monitor the contractor's performance of all contractor responsibilities. 3. Review and approve proposed corrective action(s) taken by the contractor. 4. Monitor corrective actions taken by the contractor. Iowa State staff are responsible for the following quality assurance functions, all of which are monitored at least quarterly by DHS policy staff: 1. Work with DHS to implement a quality plan that is based on proactive improvements rather than retroactive responses. 2. Develop and submit to DHS for approval, a Quality Assurance Plan establishing quality assurance procedures. 3. Designate a quality assurance coordinator who is responsible for monitoring the accuracy of the contractor's work and providing liaison between the contractor and DHS regarding contractor performance. 4. Submit quarterly reports of the quality assurance coordinator's activities, findings and corrective actions to DHS.

5. Provide quality control and assurance reports, accessible online by DHS and Contractor management staff, including tracking and reporting of quality control activities and tracking of corrective action plans.
6. For any performance falling below a state-specified level, explain the problems and identify the corrective action to improve the rating.
7. Implement a state-approved corrective action plan within the time frame negotiated with the state.
8. Provide documentation to DHS demonstrating that the corrective action is complete and meets state requirements.
9. Perform continuous workflow analysis to improve performance of Contractor functions and report the results of the analysis to DHS.
10. Provide DHS with a description of any changes to the workflow for approval prior to implementation.

Financial Accountability

The Iowa Department of Human Services has developed a computer program, named the "Individualized Services Information System" or "ISIS," that will support the program. The purpose of ISIS is to assist workers in these programs in processing and tracking requests, starting with an initial entry from the ABC system through approval or denial. Upon approval, participants will use ISIS to provide the Iowa Medicaid Enterprise with information and authority to make payments to or on behalf of a consumer. The consumer is tracked in ISIS until that consumer is no longer accessing the program. There are certain points in the ISIS process that will require contact with designated DHS central office personnel and other outside entities. These contacts must be made in order for the ISIS process to proceed. These contacts may include the HCBS program manager, and the Iowa Medicaid Enterprise medical services unit. A case normally starts with an income maintenance (IM) worker entering information into the Department's Automated Benefit Calculation (ABC) system. The ABC system passes pertinent information about the case to ISIS. Then ISIS identifies a key task (called a "milestone") for the IM worker who entered the original data into ABC. This key task is the first in a series of milestones for actions by service workers, case managers, central point of coordination administrators, and many others. These milestones form a workflow taking a request for a facility or HCBS program to denial or final approval.

In addition, the Department of Human Services Bureau of Purchased Services performs both financial and performance audits of Medicaid Providers. The billing audit is to ensure:
1. HCBS providers appropriately and accurately document the provision of services so that claims paid by the Department are eligible for reimbursement.
2. To limit the risk of providers having to refund payments to the Department because they have submitted ineligible claims.
2. To limit the risk of the Department losing or having to return matching federal funds because of having paid ineligible claims.

	At the end of each state fiscal year, an analysis of payments, recoupments and other risk related factors will be used to select and prioritize providers for billing audits to be conducted during the next auditing year (from October 1 to September 30). **Abuse, Neglect, and Exploitation** All service plans must address health and welfare of consumers. All service plans must address a back up plan for situations when service providers are not available and also an emergency plan. Providers are required to report both major and minor incidents to the state. Major incidents are to be reported within 72 hours. Providers are required to submit a report on minor incidents annually that includes any action steps that were taken to resolve incidents. The state monitors, tracks and trends all major incidents, abuse and neglect reports and complaints. For major incidents, if it appears that a consumer could be placed in eminent jeopardy, the HCBS specialist will respond immediately. For all other incident reports, the HCBS specialist will respond within 48 hours. The Child and Adult Protective Bureau within the Department of Human Services is responsible for informing the HCBS specialist of abuse and neglect reports. The HCBS specialist follows up to ensure an incident report was filed. A log is maintained that tracks the reports the follow-up that has been completed. During the QA interview process, consumers are asked if they know how to report abuse and provider files are reviewed to ensure incidents were reported. All required incident reports are sent to the IME and entered into a database. The Quality Assurance Committee reviews incident data quarterly to make policy changes and/or arrange for provider trainings. Recommendations for changes in policy are made to the IME Policy staff and Bureau Chief. The committee also uses this information to direct HCBS Specialists to provide training, technical assistance, or other activity. The committee monitors training and technical assistance activities to assure consistent implementation statewide.

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The following methods help assure quality of care and services under the Medical Assistance program.

1. A Medical Assistance Advisory Council assists the Department in planning the scope and content of medical services provided under the program.

2. The services of professional technical advisory committees are used for consultation on all services provided under the program.

3. Procedures exist to assure that workers in local Human Services offices are able to assist people in securing necessary medical services.

4. Procedures are in effect to pay for necessary transportation of recipients to and from providers of medical and health services.

5. The state has in effect a contract with the Iowa State Department of Inspections and Appeals to survey intermediate care facilities, intermediate care facilities for the mentally retarded, and skilled nursing facilities and to certify whether they meet the conditions to participate as providers of service under the Medical Assistance program.

6. The Department has in effect an Utilization Review Plan for evaluation and surveillance of the quality and quantity of all medical and health services provided under the program.

7. Physician certification, recertification and quality of care issues for the long term care patients are provided by the Iowa Foundation for Medical Care, which is the Professional Standards Review Organization in Iowa.